

RSC Policy Brief: Health Care Spending Growth

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In light of recent reports highlighting projections for future growth in health spending, the RSC has prepared a policy brief summarizing and analyzing their key conclusions.

Background: Last month, the Centers for Medicare and Medicaid Services (CMS) released its annual report projecting health care spending over the next decade. The report concluded that nationwide health expenditures are expected to rise 6.7% annually in the next ten years, causing health care spending to rise to 19.5% of gross domestic product (GDP) by 2017. These projections are consistent with a November report by the Congressional Budget Office (CBO) highlighting the long-term projections for health care spending, which estimated that health expenditures could comprise just under half (49%) of GDP within 75 years.

Ten Year Projections: The report by the CMS actuaries, released online by the journal *Health Affairs*, documents the continued growth in health care spending and hints at upcoming trends associated with the retirement of the Baby Boom generation. In 2007, health care spending is projected to have grown at a 6.7% rate, reaching \$2.2 trillion, or approximately 16.3% of GDP. The report provides a snapshot of current health expenditures, and also cites several projected spending trends over the next decade:

- Private health insurance premiums grew at a slower rate (6.0%) than overall health care expenditures in 2007, consistent with trends evident since 2004.
- Prescription drug spending grew by 6.7% in 2007, a measurable slowdown in spending when compared to the increases for the prior two years (12.0% in 2005 and 8.5% in 2006), due in large part to increased price competition and generic drug usage.
- Private spending on health care is projected to grow more slowly in the latter part of the projection period (2007-2017), while public spending “is expected to accelerate...as the leading edge of the Baby Boom generation becomes eligible for Medicare.” While the aging population will have minimal effects on overall health expenditures, its effects on public spending, particularly through Medicare, will be significant.

- Enrollment in private Medicare Advantage plans is expected to rise to 27.5% by 2017, up from 16.4% in 2006.
- Just over half of the growth in health care spending comes from increases in medical costs, with about one-quarter of the increase due to utilization (volume and intensity of services), and the remainder due to population growth, demographics, and related factors.

Overall, the report's conclusions indicate that although all health spending continues to rise, the increase in public health spending has accelerated. While the competition created by the Medicare prescription drug benefit may have contributed to the considerable slowing in pharmaceutical expenditures, an aging population moving to Medicare will only hasten the growth of public spending.

In fact, the true size of the government's future obligations for health spending is likely underestimated by the model used in the actuaries' report, which presumes that existing law adjustments in physician reimbursements under the sustainable growth rate mechanism (SGR) will take effect. If the SGR's proposed reductions are instead replaced by a 0% increase—in other words, if physician payments are held steady through 2017—Medicare spending will rise by 8.0% annually over the next decade, instead of the 7.4% projected under the trustees' current law model.

Historical Examples and Long-Term Projections: The report produced by the CMS actuaries follows on the heels of a study, conducted by CBO and released in November 2007, which examined both historical trends in health care spending and long-term projections for its growth over the next 75 years. Most notably, the report documents a historical shift in health care expenditures: a significant reduction in out-of-pocket spending, which declined from 31% to 13% of all health expenditures between 1975 and 2005, and the nearly commensurate increase in third-party payment by insurance carriers, which increased from 25% to 37% of health spending nationwide. While the growth in new technologies and services has helped drive the growth in health spending which CBO documents, the continued rise of third-party payment—which can insulate patients from the marginal costs associated with additional treatments—may well have had inflationary effects. This shift away from out-of-pocket spending occurred despite the findings of a landmark RAND Institute study, which concluded that higher cost-sharing helped constrain health care spending at little to no adverse effect on patients' health.

On a forward-looking basis, CBO projects that overall health care spending will more than double in the next thirty years, rising from 14.9% of GDP in 2005 (and 4.7% in 1975) to 31% in 2035, growing thereafter to nearly half the nation's economy (49% of GDP) in 2081. The net federal spending on Medicare and Medicaid is projected to rise at a higher rate than overall health spending, growing from 26% of total spending on health care currently to 30% within thirty years, and 38% of total spending by 2082.

These 75-year projections are materially divergent from the projections made by the Medicare trustees in their annual report. The trustees project Medicare spending to consume nearly 11% of total GDP by the end of the projection period, while CBO estimates that Medicare will consume more than one in six dollars spent in the United States (17% of GDP). As the Medicare trustees' projection notes \$36 trillion in unfunded liabilities for the program over the next 75 years, the

significantly higher projections made by CBO in its study should provide yet another impetus to enact comprehensive entitlement reform that addresses the unchecked growth in health costs.

Excess Cost Growth: Both the CMS actuaries' report and the CBO study projecting long-term health expenditures highlight the issue of excess cost growth in health care. In this context, "excess cost growth" does not imply a value judgment as to whether or not the spending is necessary or appropriate; rather, the term connotes spending that exceeds economic and productivity growth. For instance, the CMS actuaries project that health spending will rise by 6.7% over the next ten years, while nominal (i.e. non-inflation-adjusted) GDP will rise by 4.7%, resulting in excess cost growth of 2.0% annually for the decade.

The CBO report projects that the growth of overall health care spending will exceed the rate of economic growth by more than 2% annually for at least the next decade, and will continue to exceed economic growth throughout the entire 75-year projection period. The report also projects that excess cost growth for Medicare and Medicaid will continue at rates far exceeding cost growth within the private sector, noting that "that aspect of the projections may appear unrealistic, but it highlights the core problem—the unsustainability of current federal law."

Over and above the unrealistic nature of the promises made in current federal law, and the need for comprehensive entitlement reform to remedy a looming fiscal crisis for Medicare, the excess cost growth discussed in the CBO report could also have significant macroeconomic implications by displacing other spending. While CBO projects that per capita economic consumption will increase by \$15,000 (in current dollars) from 2005-2035, more than three-quarters of that higher spending will be spent on health care. Absent external action, health care costs could grow to consume all marginal increases in economic productivity—at which point both consumption and growth of other sectors of the economy could stagnate, and standards of living apart from health care (e.g. clothing, housing, etc.) could fall over time. Although this pessimistic scenario remains somewhat distant, it highlights the need to understand the factors behind the growth in health spending, and substantially reduce excess cost growth in the coming years.

Geographic Variations: Another CBO report issued in February examined one source of excess cost growth in health care: geographic variations in total spending. The report notes that state per capita health expenses in 2004 ranged from a low of about \$4,000 in Utah to a high of nearly \$6,700 in Massachusetts—a more than 50% disparity. Analysis of Medicare claims data showed a similar disparity among states—ranging from a per-beneficiary expenditure of \$5,600 in South Dakota to \$8,700 in Louisiana—and additional variations in areas within states.

The report also notes that geographic differences in price inputs (i.e. cost of labor, etc.), health status, and demographic factors (e.g. income, race, education level) likely constitute at most half of the observed deviation in expenditures, meaning that much of the geographic variation in health spending cannot be explained by known factors. In other words, similar patients with similar diseases, living in areas with similar prices, are likely to receive differing levels of medical treatments and services. Of particular note is the fact that patients living in areas with higher spending yield no better results with respect to both health processes and outcomes than patients in low-spending areas—and on some measures at least may receive worse care.

While the CBO report cites studies attributing some geographic variations in health spending to areas with a high supply of health providers (particularly hospitals and specialist physicians) creating additional demand for services, competition among a greater number of providers is likely to exert downward pressure on prices, if not the number of services performed. To the extent that geographic variation in health costs are in fact driven by excess supply, some conservatives may be wary of government efforts—such as a Certificate of Need model for approving new hospital construction, or restrictions on physician-owned specialty hospitals—that impose bureaucratic regulations to stifle the supply of health providers, as they are likely to have adverse and unintended consequences that reduce access to care. Many conservatives might prefer a more productive solution focused on mechanisms to place reasonable restraints on demand, by reducing the historical trends that have increased reliance on third-party payment, and making price and quality measures more transparent, so that consumers can have more information about available treatment options—and make a rational choice as to whether or not the additional treatment justifies the marginal cost.

Summary and Conclusions: The growth in health care spending projected in the coming decades, following upon years of sustained increases, is likely to place significant and exacting demands on both the private and public sectors of the American economy absent external action. Many conservatives believe that a discussion of ways to stem the growth in health care costs should be a part of any discussion to achieve so-called universal coverage, as health insurance would become much more affordable for all Americans at the point when premium costs and related expenditures rise at a more modest (and therefore more sustainable) rate.

The geographic variations in Medicare spending, particularly those portions of which cannot be explained by regional differences in income or health status, might prompt some Democrats to call for a centralized, government-controlled mechanism to reduce spending in higher-cost areas, likely through rationed care. One popular variation on this approach has emerged in the form of comparative effectiveness, which would attempt to conduct research on the cost-effectiveness of various treatment options with an eye towards establishing more uniform practice standards. While such efforts by the private sector could help reduce costs, many conservatives might have strong concerns as to whether a government-run effectiveness institute—such as the center proposed by Democrats in a wide-ranging health bill last July (H.R. 3162), which would have been funded by tax increases on insurance premiums—would result in a federal bureaucracy micro-managing the doctor-patient relationship, and ultimately, rationing care to patients.

A better alternative might lie in the data showing that private health spending is not rising as dramatically as expenditures on public health programs, suggesting that competition—and placing health care dollars in control of patients—holds the true solution to containing health costs. The significant decline in out-of-pocket spending over the past three decades, and the escalating rise in costs during that time, demonstrate the perils associated when third-party payment of health expenses, particularly incidental (i.e. non-catastrophic) expenses, insulates patients from the marginal costs of additional treatment. Likewise, the geographic variations in Medicare spending stem from a publicly-funded system where the costs for additional treatment can be minor—especially in areas where a high percentage of seniors own Medigap policies that can insulate beneficiaries from any increase in marginal costs.

The funding warning issued by the Medicare trustees, and the subsequent action required by Congress to act on legislation addressing this “trigger,” provides an opportunity for conservatives to construct a system designed to address the geographic variations in Medicare costs—with an impact that could stretch throughout the entire health system. An improved and enhanced Medicare system similar to the Federal Employee Health Benefits Plan (FEHBP)—where beneficiaries receive a defined contribution from Medicare to select a health plan of their choosing—would eliminate much of the geographic variations currently present within Medicare, slowing the growth of health costs and restoring the program’s long-term stability.

For further information on this issue see:

- [*Health Affairs Web Exclusive: Health Spending Projections through 2017*](#)
- [*CBO Report: The Long-Term Outlook for Health Spending*](#)
- [*CBO Report: Geographic Variation in Health Care Spending*](#)

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